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ABSTRACT

Classical models of the grieving process include Freud's concept of withdrawal of ties to the love object called decathexis, and Lindemann's emancipation from the bondage to the deceased involving adjusting to the loss in one's environment and the ability to form new relationships. Most of the models and explanations of the grieving process over the past 20 years are derived from the work of Freud and Lindemann. Recent research has challenged previous work, finding that grief from major losses may never completely end, but that the bereaved learn to live with an "empty space" in their lives. These new conclusions affect the grieving process of older persons. Grief reactions such as confusion, depression, and preoccupation with thoughts of the deceased might be mistaken for other conditions that affect the elderly such as dementias or other forms of depression and deterioration. The elderly are more prone to bereavement overload or multiple losses which could push an older person over the line of unbearability. These social expectations can aggravate older persons' grief: (1) elderly people should show a "stiff upper lip" about their losses since they should expect losses; (2) society seems uncomfortable with strong outward displays of mourning; and (3) the mourning process is becoming "deritualized" with rituals becoming briefer, simpler, and more private--a trend that could reduce the solace and support that the elderly receive from such rituals. (ABL)

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Problems with Current Models of Grieving and Consequences for Older Persons

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Abstract:

Most theories of the grieving process are derivative of Sigmund Freud's understanding of grieving as presented in Mourning and Melancholia (1917), and as formulated in Erich Lindemann's seminal study on the Symptomatology and Management of Acute Grief (1944). Implicit in these theories are the following assumptions: (1) Grieving is time-limited. The grieving process should be "resolved" after a maximum of a year or two; (2) The main task of grieving is to achieve "decathexis." One should detach one's self from the emotional ties to the deceased so as to be able to form new relationships; and (3) If grief tasks are not completed within an appropriate time limit then "abnormal" grieving will result.

This paper examines the validity of these assumptions and the consequences for older grievers. First this paper reviews current models and their assumptions. A second section reviews data in bereavement studies that raise questions about these models. Finally, the paper addresses the consequences of these models on older persons, especially as they involve such issues as bereavement overload, coping mechanisms, and the privatization and deritualization of the grieving process.

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PROBLEMS WITH CURRENT MODELS OF GRIEVING AND CONSEQUENCES FOR OLDER PERSONS

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I. CLASSICAL MODELS OF THE GRIEVING PROCESS

1) Sigmund Freud (1917). Mourning and Melancholia.

   a) Grieving is a painful process involving the withdrawal of ties (decathexis) to the "love object." The ego resists such a withdrawal through denial, by becoming preoccupied with the deceased, and through lose of interest in the outside world.

   b) The mourner eventually reviews memories and expectations of the deceased, and the griever gradually detaches himself from the lost love object, finishes the grieving process and is able to "cathect" or invest emotional energy in other relationships.

2) Erich Lindemann (1944). Symptomology and Management of Acute Grief.

   a) Grief work consists of "emancipation from the bondage to the deceased," adjusting to the loss in one's environment, and the ability to form new relationships.

   b) Working with clinical patients, Lindemann indicated that it is ordinarily possible to resolve "uncomplicated and undistorted" grief reactions in a period from four to six weeks. After a period of up to two years or so a person should be essentially finished with one's grief work as a result of emancipation or decathexis - giving up one's emotional attachment to the deceased. Failure to do grief work or to finish it will usually lead to morbid or pathological grief reactions.

II. EXPLANATIONS AND MODELS OF THE GRIEVING PROCESS OVER THE LAST TWENTY YEARS

Most of the models and explanations of the grieving process over the past twenty years are derived from the work of Freud and Lindemann and contain the following assumptions.

1) Grieving is time-limited or time-bounded. Grieving is a process that normally comes to a conclusion after a year or two. Victor Marshall (1980) calls this the "two-weeks, two-months, two-years" formula - namely, two weeks of intense grief and shock, two months of strong grieving, and two years of lessened grief, recovery, and restoration of the self and functioning.

2) The main task of grieving is to achieve "decathexis." One should detach one's self from the emotional ties to the deceased so as to be able to form new relationships. Implied in this interpretation is the assumption that the shorter the relationship, with fewer experiences, then the grieving process should also be shorter (Robert Fulton, 1987). Also implied is the assumption that the grieving process should come to a conclusion, it should end at some point.

3) If grief tasks are not completed within an appropriate time period then abnormal, maladaptive, or chronic grieving results. Implied in this assumption is that if the grieving period extends beyond one to two years, then therapeutic intervention might be needed.

Examples of explanations and models of the grieving process:

1) The following description of normal grieving by psychiatrist David Peretz (1970) is a good example incorporating most of the assumptions listed above:

"The duration of grief is variable and may range up to six months or a year. The acute phase should be over within one to two months. The progress of grief can be judged in terms of whether there is a gradual return to the level of functioning prior to the loss. It should be expected that when faced with reminders of the deceased (such as by pictures, songs, and old haunts) temporary upsurges of grief will occur even in later months. Another indication of recovery from grief includes whether new relationships are being established or interest expressed in them; particularly important for recovery from grief is the return to full capacity for pleasure without shame or guilt."

Peretz states that if the person does not "recover" or end the process by the end of one year, then mourning becomes maladaptive.

2) John Bowlby (1980) argues that the main task of the grieving process is to "detach" one's self from the emotional ties to the deceased and to redirect the self toward a new love object in one's social environment. Death causes a "disequilibrium" within one's social world. Reviewing other studies and his own clinical work, Bowlby concludes that a majority of widows do "recover" their "former state of health and well-being," in effect completing the grieving process. Yet those who do recover take two or three years to complete the process. So, mourning is time-limited but takes longer than expected. On the other hand a "substantial minority" of widows never fully recover. One can raise the question of whether their grieving is normal or maladaptive?

3) In their clinical work with widows and widowers, Colin Murray Parkes (1972 and 1986) and Robert Weiss (Parkes and Weiss, 1983) maintained that the grieving process is focused on the struggle between realizing and accepting the loss and retaining the lost object. The main goal of this process is to work through this struggle in order to be able to form new relationships. One relinquishes the lost relationship but Parkes and Weiss are not clear on how one does this. The process often lasts a year or two, but many widows viewed the adjustment

process due to bereavement as something that will continue for many years if not for the rest of their lives (Ira Glick, Robert Weiss, and Colin Murray Parkes, 1974).

4) Beverly Raphael's (1983) model of bereavement is based mainly on the work of Bowlby and Freud. The mourning process involves a review of the lost relationship, and the gradual relinquishing of the "bond" to the deceased so that the person might form new bonds or attachments.

5) Based on his clinical work, William Worden (1982) outlines four tasks to be completed during grief work. First, to accept the reality of the loss. Second, to experience the pain of grief. Third, to adjust to an environment that no longer includes the deceased. And fourth, the person must withdraw emotional energy invested in the dead person and begin to reinvest this energy in other relationships. Withdrawing emotional energy does not mean forgetting the dead person but being able to form these new relationships.

III. DATA CHALLENGING THE ASSUMPTIONS CONTAINED IN TRADITIONAL MODELS OF GRIEVING

1) Robert Fulton (1987) takes issue with the Freudian influence in our understanding of the process of mourning; namely, that the process is "time-bounded," lasting a year or two, and that the essential task of grieving is to give up one's attachment ("decathexis") to the deceased. Fulton mentions research on widows that indicates that the work of mourning does not end for many, if not for most widows. In addition, mothers of stillborn children or having had miscarriages have grief reactions that do not fit the "attachment" theories.

2) After reviewing various models, the research literature, and clinical experiences, the Committee for the Study of Health Consequences of the Stress of Bereavement (Marian Osterweis, et al, 1984) concludes that there is no clear fixed endpoint for the grieving process, that for many the process continues for a lifetime, and that there can be adjustment to the loss without a complete ending to the process or withdrawal of attachment to the deceased. In addition, it is not the length of time, by itself, that separates normal from abnormal grief reactions, but the "quality and quantity" of the reactions over time.

3) Ronald Knapp (1987) interviewed 155 families who had suffered the deaths of children, ages one to 28, and who had been bereaved for periods of three months to five years. Knapp found six significant similarities in the way families responded to the deaths of their children. The sixth was that most of the families experienced what he calls "shadow grief," a lingering, emotional dullness of affect that continues indefinitely, even years later, indicating that grief such as this is never totally resolved.

4) Sandra McClowry, et al (1987), interviewed 49 families where children had died of cancer seven to nine years previously. They describe three patterns of grieving that the families used: 1) Attempting to "get over it" by accepting the death as fate or God's will; 2)

Attempting to "fill the emptiness" by keeping busy and adopting new goals; and 3) "Keeping the connection" by integrating the pain and loss into their lives. In most cases the parents expressed pain and loss even after seven to nine years, and instead of "letting go" of the dead child, the families described the continuing presence of an "empty space" in their families.

5) William Fish (1986) did a study of differences in grief intensity between grieving parents. The study involved 77 women and 35 men who had been bereaved from one month to 16 years. Fish argues that unlike a "wound" that heals in time, the grieving process for parents is more like a "dismemberment" requiring adaptation to a loss that does not end. Dennis Klass and Samuel Marwit (1988-1989) describe this "metaphor of amputation" as the sense that a piece of the self has been cut out, that it is exaggerated in parental grief, and this sense of amputation does not diminish with time, that it is life-long. Fish also found that grief scores for mothers actually increased during years two through four, and then gradually began to decrease during year five and after, but to a level not far below scores during the first two years. Fathers grief scores decreased progressively starting with years two through four.

6) Laura Palmer (1987) interviewed the families and friends of 27 soldiers who had died in Vietnam, people who had left behind messages and mementos below the names of their dead at the Vietnam Veterans Memorial in Washington, D.C. Even though these soldiers had died 15-20 years or more ago, the survivors gave every indication that they were in a continuing grieving process, including such reactions as crying, survivor guilt, strong regrets, and in general a strong sense of loss similar to dismemberment or amputation.

7) Alice Demi and Margaret Miles (1987) did a study of the perceptions of 22 "bereavement experts" as to what constitutes "normal" grieving. The majority agreed that the bereaved should regain everyday functioning within a two to three year period, but also, that grief "may never come to an end and can still be considered normal."

8) Dale Lund, Michael Caserta, and Margaret Dimond (1986) did a longitudinal study of 192 bereaved widows and widowers between the ages of 50 and 93. One major conclusion of their study was that elderly grievers experience a long-term bereavement process that does not end at two years.

9) In a study of 70 widows and widowers, mean age 50, over a four year period, psychiatrists Zisook and Stephen Shuchter (1986), along with their clinical treatment of widows (Shuchter and Zisook, 1986), concluded that many aspects of grief work continue indefinitely for many of their subjects. In addition, they indicated that while most gradually lessen their ties to the deceased spouses, that most maintain a continuing emotional attachment to the deceased. In fact, they state that complete "decathexis" seems to be both impossible to achieve and not desirable. They argue that we need to redefine grieving tasks so that "the bereaved somehow find a way of continuing the relationship with their dead spouse that allows both an appropriate experience of

grief and continuing involvement in the living."

How the preceding data affect the assumptions contained in traditional models of grieving.

On the basis of the preceding data, when a "high grief intensity" death occurs (Robert Fulton, 1978), one can conclude that:

1) That there is no clear fixed endpoint for the grieving process, and for many the process continues for a lifetime even though they may have adjusted to the loss and recovered everyday functioning. Like an "amputation" or "dismemberment" the loss continues.

2) While most grievers lessen their emotional ties to the deceased, complete "decathexis" seems neither possible nor desireable. Most will experience a continuing attachment to and relationship with the deceased while being able to involve themselves in everyday life.

3) Bereavement involves a wide variety of reactions. Since grieving can continue for a lifetime, even after successful adjustment to the loss has been achieved, it is not the length of time, by itself, that separates normal from abnormal reactions. One must examine the quality and quantity of these reactions.

IV. HOW THESE CONCLUSIONS AFFECT THE GRIEVING PROCESS OF OLDER PERSONS

1) Since the grieving process, with its various tasks, might be lengthier than some might expect, grief related reactions such as confusion, depression, and preoccupation with thoughts of the deceased might be mistaken for other conditions that affect the elderly such as dementias or other forms of depression and deterioration (Richard Kalish, 1987). Initially some widowed persons might have positive feelings about their ability to cope with everyday tasks (Dale Lund, et al, 1986), and only later, after one or two years exhibit grief reactions that had not been expressed or experienced before.

2) The elderly are more prone than younger people to a phenomenon called "bereavement overload" (Robert Kastenbaum, 1969) or "multiple losses" (E. Freeman, 1984). Namely, the elderly are more likely to experience multiple losses over relatively brief periods of time, such as the deaths of a spouse, relatives, and friends, the loss of roles, health, income, etc. The fact that the grieving process may well extend beyond one or two years adds to the possibility that the older person's coping capacities may be overloaded. These multiple losses could push an older person beyond the "line of unbearability" (Marv Miller, 1979), to a point where the person no longer wishes to live, and even might contemplate suicide (Nancy Osgood, 1985).

3) The fact that many older persons might go through a lengthy grieving process or may never finish their mourning can be aggravated by three trends or expectations in our society. One expectation is that since losses should be anticipated with age, older people should show a "stiff upper lip" about their losses when they actually occur.

Unfortunately, studies show that such "anticipatory grief" does not necessarily eliminate nor reduce grief reactions, and sometimes complicate and increase such responses (Robert Kastenbaum, 1986). Second, our society seems uncomfortable with strong outward displays of mourning (Katy Charmaz, 1980). We expect people to do their serious grief work in "private." The elderly, more than the young, may lack available supports such as family members or confidants for assistance in working through tasks associated with the grieving process. Third, there is a growing trend toward "deritualizing" the mourning process. There is societal pressure to make our rituals briefer, simpler, and more private (Lois Pratt, 1981). This trend could reduce the solace and support that the elderly receive from such rituals.

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